MCH Title V Maternity/Prenatal Program Payment Request Form

LHD Name: _____

Patient Name: _____

Patient ID: _____

I. Medical Provider

I, _____ have determined that
(Printed Provider Name)

_____ is medically necessary and is
(Procedure Name)

pregnancy related.

Medical Indication:

CPT code(s) for requested procedure:

Is the patient considered high risk?	YES	NO

Patient EDC: _____ Patient EGA: _____ Patient G/P: _____

Medical Provider Signature:	Date:

II. Local Health Department Staff

This patient meets the financial eligibility requirements for the MCH Title V Restricted Prenatal Funds as listed below:

1. This patient is at or below 185% of the federal poverty level? YES NO
2. This patient has provided documentation of Medicaid denial? YES NO
   - If a Medicaid denial is not received, why? _____
   - If a Medicaid denial was not received, was verification of income provided? YES NO

Service date of procedure: _____

Procedure Name: _____

CPT Code Performed: _____

Additional Information:

LHD Contact Name:	Phone:
LHD Staff Signature:	Date:

III. Department for Public Health Prenatal Program

Approved for Payment:	Date Approved:	Other: